DEATH REPORTING AND

INVESTIGATION SUMMARY OF

STATUTORILY REPORTABLE DEATHS

IN 2000

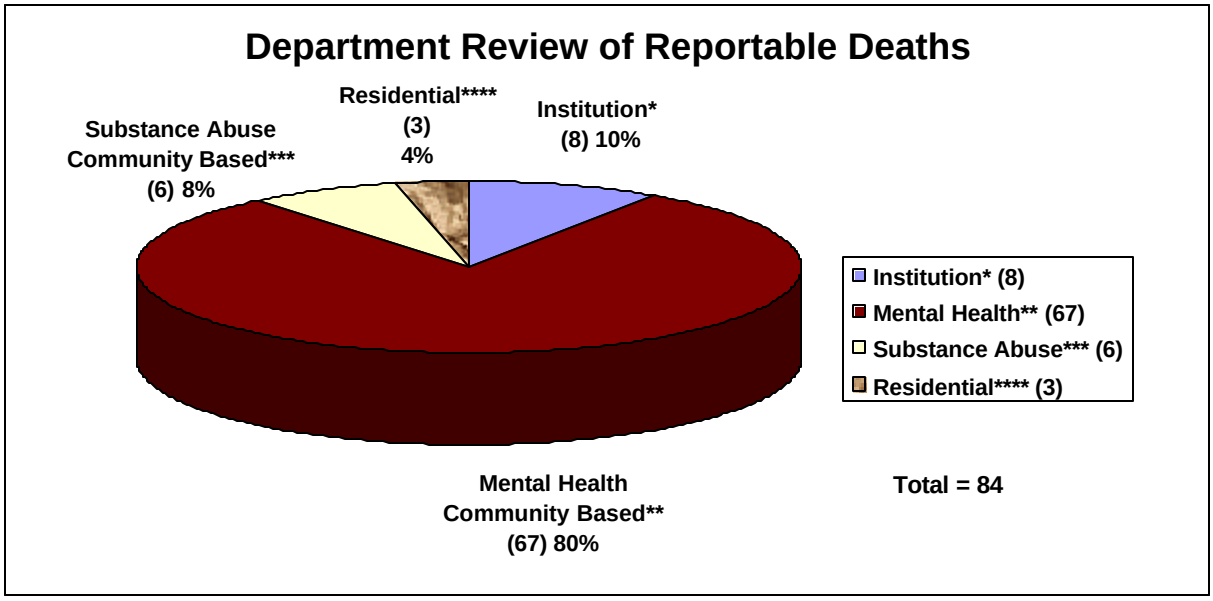
Division of Supportive Living
Department of Health and Family Services

December 2001

THE 2000 WISCONSIN STATUTORILY REPORTABLE DEATH REVIEW SUMMARY

The following summary report and graphics reflects data collected on reportable deaths under Sections 46.80(5)(a), 50.035(5), and 51,64, Wis. Stats. from January 1, 2000 through December 31, 2000. Overall, a total of 110 client/patient deaths were reported to the Department by state-certified and/or licensed programs/facilities in the treatment fields of mental health, substance abuse, developmental disabilities and long-term care. Of these, 84 deaths were determined to be reportable under the statutory requirements.

Graphic 1 shows the total numbers of reportable deaths (84) by program/facility type.



* Mental Health Inpatient Hospitals, Nursing Homes and Child Care Institutions
** Mental Health Outpatient, Community Support Programs, Mental Health Crisis Programs
*** AODA Inpatient, Outpatient, Methadone Programs, Day Treatment Programs
**** Community Based Residential Facilities

Graphic 2 shows the gender and age ranges for all reportable deaths (84).

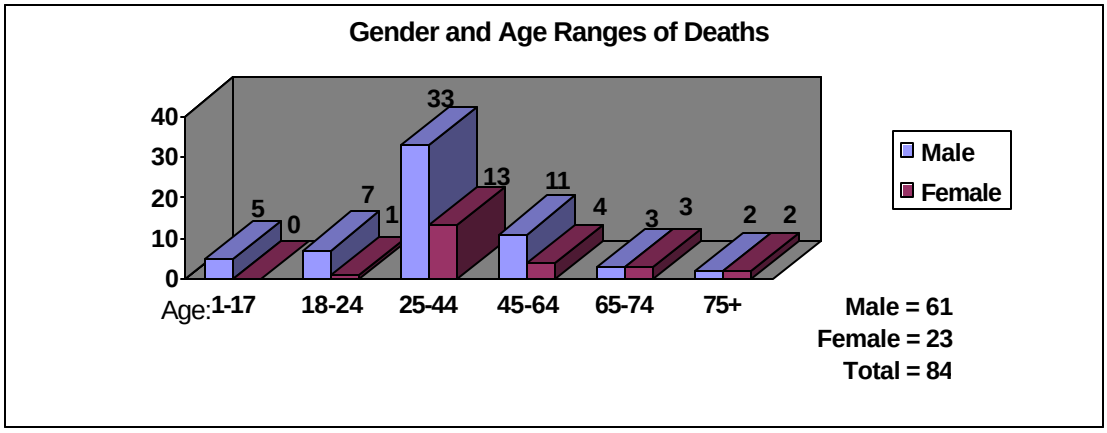


Table 1: Reportable deaths by type of program and cause of death. A comparison of data from 1996 through 2000.

PROGRAM	RESTRAINTS					SECLUSION					PSYCHOTROPIC MEDICATION					SUICIDE*					TOTALS
Year →	**'96**	**'97**	**'98**	**'99**	**'00**	**'96**	**'97**	**'98**	**'99**	**'00**	**'96**	**'97**	**'98**	**'99**	**'00**	**'96**	**'97**	**'98**	**'99**	**'00**	
Nursing Homes	3		1												1		1	1		1	**8 (3%)**
Mental Health Institutes						1										1	1			1	**4 (1%)**
Mental Health Hospitals																2	2	4	2	4	**14 (4%)**
AODA Inpatient Hospitals																			1		**1 (<1%)**
ICFs-MR for DD																					
Centers for DD																					
CSP Programs		1 [1]										1 [2]			1	9	5	6 [3]	4	4	**31 (9%)**
MH Crisis Services																1	1	2		1	**5 (1%)**
MH Day Treatment																1				1	**2 (<1%)**
AODA Detox.																	2			1	**3 (<1%)**
AODA Methadone													1 [5]						3		**4 (1%)**
RCCs					1													1			**2 (<1%)**
CBRFs															2	3	2	1	1	1	**10 (3%)**
AODA Day Treatment																			1	2	**3 (<1%)**
MH Outpatient																43	47	35 [4]	33	58	**216 (61%)**
AODA Outpatient																13	12	16	8	5	**54 (16%)**
TOTALS	**3**	**1**	**1**		**1**	**1**						**1**	**1**		**4**	**73**	**73**	**66**	**53**	**79**	**357**

CSP = Community Support Program; RCC = Residential Care Center for Children and Youth; CBRF = Community Based Residential Facility

See explanation of data with superscripts at the top of page 3

*See Suicide Data Analysis on page 3

Explanation of data with superscripts in Table 1.

1) This death, as reported by the CSP, resulted from the person being subdued by law enforcement personnel and handcuffed. While in custody he was found to be not breathing and was taken to a local hospital where he was placed on life support systems.

2) This death resulted from the individual ingesting a lethal amount of psychotropic medication. The coroner ruled the manner of death as accidental.

3) Includes 1 death reported by a CSP as a suicide which occurred in a jail

4) Includes 2 deaths reported by MH Outpatient programs as suicides which occurred in jails.

5) Cause of death was multi-drug toxicity. Manner of death was determined to be accidental.

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Suicide Data Analysis for CY 2000 Wisconsin Statutorily Reportable Deaths Reported to the Department of Health and Family Services

- Suicide deaths accounted for 79 (94%) of the 84 deaths reported to the Department. These individual deaths represent consumers of mental health, substance abuse and developmental disorder services.

- Almost three-quarters of all suicides (58 out of 79) were adult men and women aged 25 to 64.

- Over half of persons committing suicide (43 out of 79) occur in adult men aged 25 to 64.

- Males (58) are three times more likely to die from suicide than females (21).

- In the five years from 1996 to 2000, 344 consumers of services in Wisconsin died from suicide.

- Research estimates that for every suicide death there are six to eight significant others (family members and other survivors), who suffer the negative impact of suicide, often experiencing long-lasting consequences related to mental and physical well being, self esteem, and productivity. When considering only the statutorily reportable deaths for CY 2000, this represents potentially 632 men, women and children who have been assigned to the ranks of survivors of suicide.

- When the total number of suicides that occur in Wisconsin annually is considered, the number of affected individuals is even higher. For 1999, the year for which we have the most recent statewide data, there were 598 suicides in Wisconsin. Applying the above-mentioned estimates, potentially 4,784 individuals are new survivors of suicide.

- Research estimates that for every suicide death there are five inpatient hospitalizations and 22 hospital emergency department visits for suicidal behavior every year – potentially 2,133 visits per year based on the CY 2000 statutorily reportable deaths by suicide (79).
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Table 2: Department actions taken in 2000 on reportable deaths by cause of death.

Type of Action	Restraints	Psychotropic Medication	Suicides
Citations of deficiency related to the incident			3
Citations of deficiency not related to the incident		BQA = 1	1
Suspension or revocation of license/certification			
Technical assistance/consultation offered/provided	CRSC = 1	BCMH = 3	BCMH = 7 BQA = 4
Referral to Department of Reg. & Licensing			
No further department action needed			64
TOTALS	**1**	**4**	**84**

CRSC = Clinical Review Subcommittee; BCMH = Bureau of Community Mental Health; BQA = Bureau of Quality Assurance

Actions Taken by the Department in Response to Reportable Deaths

A mental health clinician with the Bureau of Community Mental Health and a participant on the Reportable Death Review Committee was involved in the following activities and actions which relate to or are, in part, an outgrowth of her work on the Reportable Death Review Committee:

- Represented the State of Wisconsin at a public hearing in Kansas City to provide additional input on the U.S. Surgeon General's recently published report, *National Strategy for Suicide Prevention: Goals and Objectives for Action.*

- Is a co-facilitator of a Wisconsin suicide prevention work group which is drafting a Wisconsin Suicide Prevention Strategy.

- Provided technical assistance/clinical consultation to four Community Support Programs, and to three community-based mental health programs. Technical assistance/clinical consultation included site visits for in-service training, medical record reviews, telephone consultations, and sharing resource information with community support program staff.

- Provided technical assistance/clinical consultation to staff within the Department on issues related to policy and procedure development on suicide prevention strategies including risk assessment and management strategies, medication management of psychotropic medications.

- Provided technical assistance/resource information on suicide and suicide prevention to Department of Corrections staff.